Department of Medical Assistance Services
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http://www.dmas.state.va.us

MEDICAID MEMO

TO: All Providers of Nursing Facility Services

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 9/26/2014

SUBJECT: Implementation of Nursing Facility Price-Based Payment — Effective November 1, 2014

The purpose of this memo is to inform you of new billing requirements for nursing facilities, effective November 1, 2014. In a Medicaid Memo dated June 9 and revised June 25, 2014, DMAS notified providers of the change in reimbursement policy and described the new price-based payment methodology. Prior to July 1, 2014, Medicaid reimbursed all nursing facilities for operating costs utilizing a facility-specific per diem rate that was set prospectively based on prior year costs. Effective for claims with dates of service on or after July 1, 2014, DMAS began paying nursing facilities using a new price-based payment methodology. For claims with dates of service between July 1 and October 31, 2014, no billing changes were necessary because each facility's claims are paid the same per diem rates.

Claim Billing Information

For dates of service on or after November 1, 2014, there will be billing changes that will require facilities to submit Resource Utilization Group (RUG) codes on the claim. The direct cost component will be adjusted by the RUG weight on each claim. The Medicaid process will be a simplified version of the process used by Medicare and will use the Medicaid RUG III, 34 grouper, version 5.12.

Claims will continue to be billed on the UB-04 claim form, the 837I electronic format, or entered through Direct Data Entry by the provider as currently billed. Please adjust billing practices in the following manner:

Revenue and Procedure Codes

Under the new methodology, in addition to billing the revenue codes for room and board and ancillary services, each nursing facility claim must contain one revenue code "0022" for each distinct billing period of the nursing facility stay. The RUG code determined by the RUG-III, 34 grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment should be reported in the last two digits of the HIPPS rate code. The total charges for revenue code 0022 should be zero. See example of values to be reported.

Revenue Code	HIPPS Rate Code	Units	Billed Charges	Non-Covered Amount
0022	BB201	30	0.00	0.00

Revenue Units

The units reported on the revenue line for 0022 must represent the days covered during the billing period. The total accommodation days/room and board units reported should equal total units for each revenue code 0022 line.

Unlike Medicare, if there is a change in the RUG assignment during the billing period, a separate claim should be submitted with revenue code "0022" and the new RUG code should be reported for the dates of service to which the new RUG assignment applies. The new RUG code should not be billed until the MDS assessment has been completed and accepted in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Once the MDS submission is transmitted and accepted, the new RUG should be billed retroactive to the Assessment Reference Date (ARD) for the MDS submission for the RUG. Nursing facilities should continue to follow the existing MDS guidelines for submitting assessments including any significant change in patient status.

Significant Change
To reflect a significant change in the patient status outside of the required quarterly assessment nursing facilities should continue to submit a Significant Change Status Assessment (SCSA). The SCSA restarts the schedule for the next Omnibus Budget Reconciliation Act (OBRA) quarterly assessment due in 92 days.

Late Assessments
If the OBRA quarterly assessment is not completed within in the timelines as defined by the requirements in the Resident Assessment Instrument (RAI) manual published by CMS, the assessment shall be considered late. The nursing facility shall bill the default RUG code until a new assessment has been completed and accepted.

Assessments for Stays Less than 14 Days
If a resident is in the nursing facility less than 14 days, the nursing facility may bill the admission MDS assessment if completed. If the resident is discharged before the Admission MDS assessment is completed, the nursing facility shall bill the default RUG code.

EDIT Information:

The following edits will be used in nursing facility price-based payment processing:

Edit/ESC	Description
1726	Invalid RUG Group/RUG Group Not Found
1727	Invalid RUG Units
1728	Calculated RUG Amount is Zero

Crossover Claims: Medicare (RUG-IV, Grouper 66)
For Medicare crossover claims, DMAS shall map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG-III, grouper 34 RUG code. The map is available on the DMAS website. The Medicaid RUG weight in effect for the date of services will be used to determine the direct operating per diem.

Nursing Facility Price-Based Example
State Fiscal Year (SFY) 2015 Transition Claim Per Diem Example – July 1, 2014 to October 31, 2014
Each facility's direct rate component will be case mix adjusted using the average facility case mix for 3rd and 4th quarters 2013 (last two final case mix scores available prior to July 1, 2014).

Direct Operating Rate (Case-Mix Neutral)	$83.27
Facility Case Mix Adjustment	1.0257
Case-Mix Adjusted Direct Operating Rate	$85.41
Indirect Operating Rate	$ 65.81
Capital Rate	$13.07
Nurse Aide Training and Competency Evaluation Program (NATCEPs) Rate	$0.00
Criminal Records Check (CRC) Rate	$0.01
Total Facility Per Diem	$164.30

SFY 2015 Transition Claim Per Diem Example – November 1, 2014 to June 30, 2015

The direct rate component of each claim will be calculated based on the RUG weight (case-mix score) during the claim period.

RUG-III, Grouper 34 Group Examples	SE3	CC2	RAB	BB2	IA2
Direct Operating Rate (Case-Mix Neutral)	$83.27	$83.27	$83.27	$83.27	$83.27
RUG-III, Grouper 34 Weight	2.10	1.42	1.24	0.86	0.72
RUG-Adjusted Direct Operating Rate	$174.87	$118.24	$103.25	$71.61	$59.95
Indirect Operating Rate	$ 65.85	$ 65.85	$ 65.85	$ 65.85	$ 65.85
Capital Rate	$13.07	$13.07	$13.07	$13.07	$13.07
NATCEPs Rate	$0.00	$0.00	$0.00	$0.00	$0.00
CRC Rate	$0.01	$0.01	$0.01	$0.01	$0.01
Total Facility Per Diem by RUG Category	**$253.80**	**$197.17**	**$182.18**	**$150.54**	**$138.88**

Total reimbursement shall equal the total facility per diem multiplied by the approved payment days for each billing period.

Rate Posting and Questions

The rates effective November 1 are being revised to correct an error in the calculation of the indirect cost day-weighted medians for three of the five indirect peer groups. Claims for dates of service on or after November 1, 2014 will be reimbursed the revised rates posted on the DMAS website.

Rates, weights, and Frequently Asked Questions (FAQs) have been posted to the DMAS website at www.dmas.virginia.gov under Provider Services, Rate Setting Information, Nursing Facilities or the rate setting home page at http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx under Nursing Facilities. The RUG weights and rates for November 1, 2014 to June 30, 2015 are posted separately from the case-mix adjusted rates for July 1, 2014 to October 31, 2014. If you have any questions regarding changes to the nursing facility payment methodology you may contact DMAS at the following address NFPayment@dmas.virginia.gov.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance
1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.